VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: RODGER A. FRASER, M.D.
License No.: 0101-053053

CONSENT ORDER

By Order dated February 8, 2002, the Virginia Board of Medicine ("Board") summarily suspended the license of Rodger A. Fraser, M.D., to practice medicine and surgery in the Commonwealth of Virginia. Simultaneously, Dr. Fraser was noticed for a formal administrative hearing to inquire into allegations that he may have violated certain laws governing the practice of medicine in Virginia. By letter dated February 20, 2002, Mary M. H. Priddy, Esq., counsel for Dr. Fraser, requested a continuance of this proceeding, which was granted by the Board. The hearing was to be scheduled during the Board meeting of October 10-12, 2002.

In lieu of proceeding to this formal hearing, the Board and Dr. Fraser, as evidenced by their signatures affixed below, agree to enter into this Consent Order affecting the license of Dr. Fraser to practice medicine in Virginia.

FINDINGS OF FACT

The Board adopts the following findings in this matter:

1. On or about November 20, 2001, Patient A, accompanied by her boyfriend, presented to Dr. Fraser at the Commonwealth Women's Clinic, Falls Church, Virginia, for an elective abortion. Patient A's last monthly period was documented on her intake form as "Aug. 01 9/2" (sic). Dr. Fraser recorded that his bimanual examination confirmed an 11-13 week sized uterus. Without performing an appropriate pre-operative evaluation, Dr. Fraser initiated the abortion. Dr. Fraser stated to the Board's investigator that the fetal parts he removed were more developed than an 11 or 12-week-old fetus; instead they were comparable to that of an 18 to 20-week-old fetus.

2. During the procedure, Dr. Fraser perforated Patient A's uterus, damaging her bowel and causing her to hemorrhage. Dr. Fraser instructed the staff to call paramedics for transport to a local hospital.

3. At no time did Dr. Fraser speak to Patient A or her boyfriend, nor did Dr. Fraser explain to Patient A or her boyfriend the reason for her transport to the hospital.

4. Patient A was taken to INOVA Fairfax Hospital via ambulance. Dr. Fraser abandoned Patient A when he sent her to the hospital with insufficient documentation or guidance explaining Patient A's condition. Dr. Fraser failed to directly communicate with any of the hospital's physicians until after the hospital staff took multiple affirmative and active steps to contact Dr. Fraser. Specifically, Dr. Fraser stated in his interview with the DHP Investigator ("investigator") that he informed an emergency room nurse that he was sending in a patient, but failed to speak to a physician on duty and failed to sufficiently explain the patient's condition. According to hospital staff, the medical record he sent with Patient A was illegible. Shortly after transfer, attempts by the hospital staff to contact Dr. Fraser regarding Patient A's condition were unsuccessful. When Dr. Fraser eventually contacted a resident later that night, the hospital had already determined the severity of the injury. During this conversation, Dr. Fraser reported to the resident a larger than expected fetus, and stated that he saw an undamaged loop of bowel after removing several fetal parts. This information was used to re-confirm the hospital's findings. Until Dr. Fraser returned the hospital's calls, all communication by Dr. Fraser to any doctors at the hospital were through third parties.

5. Patient A was admitted to INOVA Hospital and underwent an emergency exploratory laparotomy, which revealed a large gaping defect in the low posterior uterus and a mesenteric injury to the sigmoid colon with resultant vascular compromise. Further, an ossified fetal head with a biparietal diameter of 5.6 cm. was extracted from the uterus. Due to the extent of her injuries, Patient A required a supracervical hysterectomy and a Hartmann's procedure with end colostomy.

6. Upon review of the evidence, Dr. Fraser made numerous inconsistent statements and medical record entries. Specifically:

- In Dr. Fraser's letter to the Board, he stated that he introduced himself to Patient A, explained the procedure, and examined her chest and heart. However, in his interview with the investigator, Dr. Fraser said he did not speak to Patient A because she did not speak English. The investigator confirmed the fact that Patient A could not speak English, and confirmed that neither she nor her boyfriend spoke with Dr. Fraser
- In his letter to the Board, Dr. Fraser stated that no ultrasound was taken because the machine was either broken or out of film. However, in his interview with the investigator, Dr. Frasier said that a nurse did not take an ultrasound before the procedure because she did not have time. He later stated that he performed an ultrasound on Patient A during the procedure. When asked about the identity of the nurse, he could not remember her name, and he believed that she was no longer with the clinic.
- In his letter to the Board, Dr. Fraser stated that a staff member from the clinic followed Patient A to the hospital; however, he failed to identify that staff member. Further, the hospital records do not indicate that a staff member was present at the hospital's emergency room.
- In his initial exam, Dr. Fraser noted the age of the fetus at 11 weeks on the physical examination form, yet when the hospital was contacted after the procedure, Dr. Fraser estimated the age of the fetus to be 15-20 weeks. Also, on the examination form, Dr. Fraser noted that the placenta was the only product of conception examined and identified and the tissue appeared normal and was consistent with a complete abortion of an eight-week sized fetus, and Patient A was sent to the recovery lounge in good condition.

- In his letter to the Board and his statement to the investigator, Dr. Fraser stated that the cause of Patient A's bleeding was placenta previa and that he confirmed this finding by ultrasound. The clinic's records contain no reference to placenta previa and Dr. Fraser did not report this condition to staff or physicians at the hospital.

7. On February 2, 2002, Patient B, accompanied by her boyfriend, presented to Dr. Fraser at A Capitol Women's Health Clinic, Richmond, Virginia, for an elective abortion. During the procedure Dr. Fraser perforated Patient B's uterus and lacerated her cervix, and left products of conception in her uterus and abdominal cavity. Dr. Fraser ended the procedure, telling Patient B that she appeared too tired to continue, and that she had products of conception in the uterus, but that they would pass in the next few days. Patient B reported that she had difficulty walking and could not stand up straight as she left the facility.

8. On February 4, 2002, Patient B was admitted to the emergency room of the Medical College of Virginia Hospital, Richmond, Virginia. During the examination, a cervical laceration on the anterior lip junction with vaginal mucosa was noted, and surgery revealed a perforation in the anterior in the mid-lower uterine segment. Products were removed from the uterus and the abdominal cavity. The cervical laceration and the uterine perforation were repaired, and Patient B was released from the hospital on February 6, 2002.

9. On February 8, 2002 Dr. Fraser's license to practice medicine and surgery in the Commonwealth of Virginia was summarily suspended by the Board, and notice of the suspension was personally served him on that same day.

10. On February 9, 2002, Dr. Fraser provided treatment to twenty-four (24) patients (Patients C-Z) and performed twenty-three (23) abortions at the Clinic located in Richmond, Virginia.

11. On June 12, 2002, Dr. Fraser was convicted in Henrico County Circuit Court of four (4) counts of practicing medicine without a license, all felonies.

12. Dr. Fraser failed to list his practice at Commonwealth Women's Clinic, Falls Church,

Virginia, as a primary or secondary practice location and he wrongly stated that he had admitting privileges at Chippenham Medical Center, on his Virginia Practitioner Profile.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes that Dr. Fraser is in violation of Sections 54.1-111.A(1); 54.1-2902; 54.1-2910.1; 54.1-2915.A(1), (4) and (3), as further defined in Section 54.1-2914.A(1), (5), (7), (8), (11), and (13); and 54.1-2916.A(1) of the Code of Virginia (1950), as amended.

CONSENT

I, Rodger A. Fraser, M.D., by affixing my signature hereto, acknowledge that:

1. I have been advised specifically to seek the advice of counsel prior to signing this document;

2. I am fully aware that without my consent, no legal action can be taken against me, except pursuant to the Virginia Administrative Process Act, § 2.2-4000 A et seq. of the Code of Virginia;

3. I have the following rights, among others:

   a. the right to a formal fact-finding hearing before the Board;

   b. the right to representation by counsel; and

   c. the right to cross-examine witnesses against me.

4. I waive all rights to a formal hearing;

5. I neither admit nor deny the truth of the above Findings of Fact; and

6. I consent to the following Order affecting my license to practice medicine in the Commonwealth of Virginia.

ORDER

WHEREFORE, based on the foregoing Findings of fact and Conclusions of Law, and with the consent of the licensee, it is hereby ORDERED that the Board accepts the SURRENDER for PERMANENT REVOCATION of Dr. Fraser's license to practice medicine and surgery in the Commonwealth of Virginia.

Pursuant to Sections and 54.1-2920 of the Code, upon entry of this Consent Order, Dr. Fraser shall forthwith give notice, by certified mail, of the revocation of his license to practice medicine to all patients to whom he is currently providing services. Dr. Fraser shall cooperate with other practitioners to ensure continuation of treatment in conformity with the wishes of the patient. Dr. Fraser shall also notify any hospitals or other facilities where he is currently granted privileges, and any health insurance companies, health insurance administrators or health maintenance organization currently reimbursing him for any of the healing arts.

Upon entry of this Consent Order, the license of Dr. Fraser will be recorded as revoked and no longer current.

Pursuant to Section 9-6.14:14 of the Code, the signed original of this Consent Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD:

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

8/30/02
ENTERED

SEEN AND AGREED TO:

Rodger A. Fraser, M.D.

STATE OF Virginia
COUNTY/~~CITY~~ OF Henrico, TO WIT:

I, Subscribed and sworn to before me, the undersigned Notary Public, in and for the State of Virginia, at large, this 26th day of August, 2002, by Rodger A. Fraser, M.D.

Notary Public

My commission expires: 11-30-02

ME/FraserCO.DOC